

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

21 Item 20&Film 217 6-28-57 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
6241 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 282 06231											
1. PLACE OF DEATH a. COUNTY <i>Charles</i>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Colorado</i> b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Haldorf</i>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Littleton 44X-3</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <i>Colorado</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>ALVIN C. BIRZA</i>				4. DATE OF DEATH Month <i>6</i> Day <i>15</i> Year <i>1957</i>							
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-9-35</i>		9. AGE (In years last birthday) <i>22</i> Yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <i>NAVY</i>				11. BIRTHPLACE (State or foreign country) <i>Colorado</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles</i>				14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>				16. SOCIAL SECURITY NO. <i>437-08-55</i>				17. INFORMANT <i>US NAS - POTOMENT RIVER, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>fractured skull</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Riding as outside front seat passenger of 3 in a convertible. Conv. made a turn and grazed a tree as Mr. Birza's head hit tree</i> 20c. TIME OF INJURY Month, Day, Year <i>6-15-57</i> Hour <i>1</i> a.m. <i>7</i> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Haldorf</i> 20f. (City or town) <i>Haldorf</i> (County) <i>Charles</i> (State) <i>Colo</i> 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . ACTUAL SIGNATURE <i>E J EDELEN</i> EXAMINER'S NAME (Type) <i>E J EDELEN</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>6-15-57</i> 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>TRANSPORTATION</i> 22b. DATE THEREOF <i>6-18-57</i> 22c. NAME OF CEMETERY OR CREMATORY <i>DENVER, Colorado</i> 22d. LOCATION (City, town, or county) (State) 23. FUNERAL DIRECTOR'S SIGNATURE <i>P. B. Robinson - Leonardtown, Md.</i> ADDRESS <i>6/20/57</i> 24a. REC'D BY REGISTRAR <i>Alvan L. Hauser</i> 24b. REGISTRAR'S SIGNATURE											

JUN 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6242

CERTIFICATE OF DEATH

06232

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Phy Mem Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>W.</u> Last <u>BOWLING</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 13, 1878</u> 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wallace T Bowlsby</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Dolman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Margaret Crooksey Dentwelle</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremia - renal apoplexy</u> DUE TO (c) <u>610 x Benign prostatic hypertrophy &amp; obstruction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>5 days</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE-CONDITION GIVEN IN PART I (a) <u>Bilateral inguinal hernias &amp; partial obstruction</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>56</u> , to <u>6-4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-4</u> , 19 <u>57</u> , and that death occurred at <u>2:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. M. JOHANSON</u> M.D.		ADDRESS (Street, city or town, state) <u>La Plata, Md.</u> DATE SIGNED <u>6-5-57</u>	
PHYSICIAN'S NAME (Type) <u>F. M. JOHANSON</u> M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>6/7/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dentwelle M.C.</u>	22d. LOCATION (City, town, or county) (State) <u>Dentwelle Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Lee LaPlata</u>		24a. REC'D BY REGISTRAR DATE <u>6/10/57</u>	24b. REGISTRAR'S SIGNATURE <u>Julia H. Pacey</u>

BUREAU V. S.

12 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
6243 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Item 9 Film 0217 7-12-57 et									
Reg. Dist. No. 07378 105									
1. PLACE OF DEATH a. COUNTY <u>Charles</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>CHARLES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 WALDORE</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>LUTHER</u> Last <u>BUTLER</u>					4. DATE OF DEATH Month <u>6</u> Day <u>29</u> Year <u>1957</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-15-1902</u>		9. AGE (In years last birthday) <u>55</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>what ever available</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
13. FATHER'S NAME <u>John BUTLER</u>					14. MOTHER'S MAIDEN NAME <u>Georgia BROWN</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNK.</u>		17. INFORMANT <u>LENNIE KENT</u> Address <u>921 N J AVE., SE Wash. D.C.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 983X DUE TO <u>Commotus frons of skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hit a Club</u> DUE TO <u>Hit a Club</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>6-29-57</u> <u>6-29-57</u> <u>6-29-57</u>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hit a club</u>					
20c. TIME OF INJURY Month, Day, Year <u>6-29-1957</u> Hour <u>7</u> <u>a.m.</u> <u>p.m.</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Waldorf</u> (County) <u>Charles</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>E. J. EDELEN</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u> MD					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-3-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley Cem.</u>		22d. LOCATION (City, town, or county) <u>Waldorf</u> (State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>HUNCE FUNERAL Home</u> ADDRESS <u>WALDORE, MD.</u>					24a. REC'D BY REGISTRAR <u>JUL 8 1957</u>		24b. REGISTRAR'S SIGNATURE <u>M. L. Morris</u>		

DATE SIGNED

7-1-57



MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 8 1957

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-58 1PM

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06233

106

Reg. Dist. No. ....

6244

## CERTIFICATE OF DEATH

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Rural-Indian Head Md</u>		<u>6 yrs.</u>		TOWN <u>Rural-Indian Head Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				1			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>George Carroll Casto</u>				<u>6-8-57</u> 19			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<u>Male</u>	<u>White-US</u>	<u>Married</u>	<u>9-22-1889</u>	<u>67</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if Hospital Attendant)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> Medical Care		<b>11. BIRTHPLACE</b> (State or foreign country) Morgantown-West Virginia		<b>12. CITIZEN OF WHAT COUNTRY?</b> USA	
<b>13. FATHER'S NAME</b> UNK				<b>14. MOTHER'S MAIDEN NAME</b> UNK			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> 220-07757		<b>17. INFORMANT &amp; ADDRESS</b> Wife-Mrs Geo Casto, Bryans Road Md			
<u>No</u>							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>IMMEDIATE CAUSE</b> (A) <u>General Asthenia</u>						<u>One Month</u>	
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <u>Bronchio-Genic Carcinoma</u>						<u>One Year</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO</b> (C) <u>Cerebral Metastases</u>						<u>6-Mths</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from August 1, 1956, to 6-8-57, 19....., that I last saw the deceased alive on 6-8-57, 19....., and that death occurred at 2:30P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>James Stendrews</u> M.D.				<b>DATE SIGNED</b> <u>6-8-57</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>				<b>24. REC'D BY REGISTRAR</b> <u>Mrs. Odey Pruep</u>			
<b>DATE</b> <u>JUN 12 1957</u>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The Hunt Funeral Home</u>		<b>ADDRESS</b> <u>Waldorf, Md.</u>	





Reg. Dist. No. .... 720

6245

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

## INSTRUCTIONS

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	CHARLES	COUNTY	CHARLES
CITY (If outside corporate limits, write RURAL and give nearest town)	LA PLATA	CITY (If outside corporate limits, write RURAL and give nearest town)	WICOMICO
HOSPITAL OR INSTITUTION OR STREET ADDRESS	PHYSICIANS MEMORIAL	STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
JOHN CARROLL CLEMENTS		6-8-57	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
M	W	MARRIED	OCT 19 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
STOREKEEPER		RETAIL	CHARLES COUNTY, MD.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
ROBERT LEE CLEMENTS		FLORENCE THOMPSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
YES			MARY L. CLEMENTS WICOMICO, MD.
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
153X IMMEDIATE CAUSE (A) INTESINAN OBSTRUCTION			3 DAYS
ANTECEDENT CAUSE(S) DUE TO (B) NEOPLASTIC PERITONITIS			3 MOS.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) ADENOCARCINOMA OF APPENDIX			14 MOS.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
6-7-57		EXTENSIVE ADENOCARCINOMA - ABDOMEN	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from APRIL 8, 1956, to JUNE 8, 1957, that I last saw the deceased alive on JUNE 8, 1957, and that death occurred at 4:00 P.M. from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
L. J. JARVIS, M.D.		6-8-57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR	
BURIAL		REGISTRAR'S SIGNATURE	
DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
6-11-57		ST MARY'S CEM.	
LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE	
NEWPORT, MD.		HUNTT FUNERAL HOME	
DATE		ADDRESS	
JUL 10 1957		WALDOFF, MD.	

# CERTIFICATE OF DEATH

Form 10-1-54

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF BURIAL SOCIETY

15. SIGNATURE OF CHURCH

16. SIGNATURE OF OTHER

17. SIGNATURE OF

18. SIGNATURE OF

19. SIGNATURE OF

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BUREAU V. 1

JUN 12 1957

RECEIVED

NOTIFICATION

SAVING IN AN EVIDENCE OF  
TO MARYLAND DEPARTMENT OF HEALTH  
BALTIMORE, MARYLAND

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6246 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06235

Reg. Dist. No.

100

<b>1. PLACE OF DEATH</b> a. COUNTY <u>CHARLES</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRYANTOWN</u> c. LENGTH OF STAY IN 1b <u>16 YRS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 BRYANTOWN</u> d. STREET ADDRESS <u>1 (RURAL)</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>WARREN LEVI DENT</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>JUNE 12 1957</u>							
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>W-US</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>MAY 20, 1875</u>		<b>9. AGE</b> (In years last birthday) <u>82</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>U.S. CIVIL SERVICE FOREMAN</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>FOREMAN</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>FREDERICK DENT</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>MARY DENT</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>				<b>16. SOCIAL SECURITY NO.</b> _____				<b>17. INFORMANT</b> Address <u>MRS. WARREN DENT: BRYANTOWN, MD</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART</u> <u>ARTERIO SCLEROTIC DISEASE (CARDIAC FAILURE)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIO-SCLEROSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u> (b) _____ (c) _____										INTERVAL BETWEEN ONSET AND DEATH <u>INSTANTANEOUS</u> <u>20 YRS.</u>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>450.0</u>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. _____ 19				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <u>John N. Griffin</u> M.D.						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			<b>DATE SIGNED</b> <u>6/12/57</u>		
<b>EXAMINER'S NAME (Type)</b> <u>acting</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>June 15, 1957</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Old Fields</u>				<b>22d. LOCATION (City, town, or county)</b> _____ (State) _____	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Hunt Funeral Home</u>						<b>ADDRESS</b> <u>Waldorf Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>JUN 17 1957</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Julia Posey</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. Includes checkboxes for various conditions and a large area for the examiner's signature and notes.

BUREAU V. 3

JUN 17 1957

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06236

## CERTIFICATE OF DEATH

6247

Item 7 Film G216 6-19-57 et

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles</u>		STATE <u>Maryland</u>		COUNTY <u>Charles</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		LENGTH OF STAY (in this place) <u>1</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bryans Road, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hospital</u>				STREET ADDRESS <u>1</u>		(If rural give location)	
<b>3. NAME OF DECEASED</b>				<b>4. DATE OF DEATH</b>			
(First) <u>William A.</u>		(Middle) <u>Dyson</u>		(Last) <u>Dyson</u>		(Date) <u>June 15 1957</u>	
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>Col.</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> <u>78</u> yrs.	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>retired</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S.</u>	
<b>13. FATHER'S NAME</b> <u>Sidney Dyson</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Sophie ?</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Walter L. King Wash. D.C.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>331X IMMEDIATE CAUSE (A)</b> <u>Hemorrhage into meningis</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 day</u>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>12 AM</u>, 19<u>57</u>, to <u>10 PM</u>, 19<u>57</u>, that I last saw the deceased alive on <u>14 PM</u>, 19<u>57</u>, and that death occurred at <u>8:15 PM</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>[Signature]</u>				<b>DATE SIGNED</b> <u>6-15-57</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>				<b>ADDRESS (Street, city, town, state)</b>			
<b>DATE THEREOF</b> <u>6-19-57</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Metropolitan M. E.</u>		<b>LOCATION (City, town, or county)</b> <u>Pomonoke Md.</u>		<b>(State)</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Julia Pasqua</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Barnes &amp; Matthews</u>			
<b>DATE</b> <u>JUN 17 1957</u>				<b>ADDRESS</b> <u>614-4" &amp; S.W.</u>			



# CERTIFICATE OF DEATH

Form 100-10

1. NAME OF DECEASED

2. SEX

3. RACE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. TIME OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF CHURCH OFFICIAL

18. SIGNATURE OF FUNERAL HOME

19. SIGNATURE OF CEMETERY

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF INTERVIEWER

25. SIGNATURE OF INTERVIEWER

26. SIGNATURE OF INTERVIEWER

27. SIGNATURE OF INTERVIEWER

28. SIGNATURE OF INTERVIEWER

29. SIGNATURE OF INTERVIEWER

30. SIGNATURE OF INTERVIEWER

BUREAU V. 3

JUN 17 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6248 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Potomac Heights</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Dispensary Indian Head Md</b>				d. STREET ADDRESS <b>56 Elder Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Milton</b> Last <b>Forestell</b>				4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-5-96</b>	9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Catering Service</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Civ. Serv. (Ret)</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Forestell</b>				14. MOTHER'S MAIDEN NAME <b>Not Known</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>220326172</b>		17. INFORMANT <b>Mrs E M. Forestell, Indian Head Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (b) <b>Chronic Myocarditis</b> (a), stating the underlying cause lost. <b>422.2</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Had Coronary Occlusion 2 years ago and was under treatment</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>For b 18</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank A. Susan</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank A. Susan M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>6/19/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co. Wash D.C.</b>				24a. REC'D BY REGISTRAR <b>DATE 4/13/57</b>		24b. REGISTRAR'S SIGNATURE <b>Odey Price</b>	

DATE SIGNED

**6-13-57**

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH - BALTIMORE, MD.  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]  
 SEX: [illegible] AGE: [illegible]  
 OCCUPATION: [illegible]  
 PLACE OF BIRTH: [illegible]  
 DATE OF BIRTH: [illegible]  
 DATE OF DEATH: [illegible]  
 TIME OF DEATH: [illegible]  
 PLACE OF DEATH: [illegible]  
 CAUSE OF DEATH: [illegible]  
 MANNER OF DEATH: [illegible]  
 SIGNATURE OF EXAMINER: [illegible]  
 OFFICE OF EXAMINER: [illegible]

BUREAU Y. B.

JUN 20 1907

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6243 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06238

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Chas</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kepler</i>		c. LENGTH OF STAY IN 1b <i>1 yr</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kepler</i>		d. STREET ADDRESS <i>x2</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>SANDRA ROBBIN GILROY</i>				4. DATE OF DEATH Month <i>6</i> Day <i>26</i> Year <i>1957</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-31-56</i>		9. AGE (In years last birthday) <i>1</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Floyd Collins Gilroy</i>				14. MOTHER'S MAIDEN NAME <i>Dorothy Mae Johnson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Thinner carbon monoxide</i> DUE TO <i>Crushed Skull</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <i>Truck ran over head</i> INTERVAL BETWEEN ONSET AND DEATH <i>6-26-57</i> <i>6-26-57</i> <i>6-26-57</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Truck backed over its head</i>					
20c. TIME OF INJURY Month, Day, Year <i>June 26 1957</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, store, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Kepler</i> (County) <i>Chas</i> (State) <i>MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. J. Edelen</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-29-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>West</i>		22d. LOCATION (City, town, or county) <i>Kepler</i> (State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archant</i> ADDRESS <i>Kepler MD</i>				24a. REC'D BY REGISTRAR <i>7/1/57</i>		24b. REGISTRAR'S SIGNATURE <i>John H. Paacy</i>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 81

3 1957

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06239

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

6250

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles Co</u>		MARYLAND		STATE		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lopata md</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Belton md</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Phy mem 24 unit</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Infant</u> (Middle) <u>mill</u> (Last) <u>Harvey</u>				(Month) <u>June</u> (Day) <u>14</u> (Year) <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>June 13, 1957</u>	9. AGE last birthday yrs. <u>14</u>		IF UNDER 1 YEAR Months <u>14</u> Days <u>19</u> Hours <u>57</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Charles Co md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Leonard Harvey</u>				14. MOTHER'S MAIDEN NAME <u>Ann Mills</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Leonard Harvey</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
7640 IMMEDIATE CAUSE (A) <u>Inf. di. as above</u>						6-14-57	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.</b>							
SIGNATURE <u>E. J. Decker</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>6-17-57</u>		NAME OF CEMETERY OR CREMATORY <u>Our Property</u>		LOCATION (City, town, or county) (State) <u>Belton md</u>	
24. REC'D BY REGISTRAR DATE <u>6/18/57</u>		REGISTRAR'S SIGNATURE <u>Julia H. Passey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Archibald Inc</u>		ADDRESS <u>Lopata md</u>	

4000141XVII

# CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NAME - SURNAME FIRST MIDDLE INITIAL

NAME OF PLACE

DATE OF BIRTH

SEX

PLACE OF BIRTH

CITY

STATE

COUNTRY

DATE OF DEATH

TIME

PLACE OF DEATH

CITY

STATE

COUNTRY

DATE OF INTERMENT

TIME

PLACE OF INTERMENT

CITY

STATE

COUNTRY

DATE OF BURIAL

TIME

PLACE OF BURIAL

CITY

STATE

COUNTRY

DATE OF CREMATION

TIME

PLACE OF CREMATION

CITY

STATE

COUNTRY

DATE OF EXHUMATION

TIME

PLACE OF EXHUMATION

CITY

STATE

COUNTRY

DATE OF REINTERMENT

TIME

PLACE OF REINTERMENT

CITY

STATE

COUNTRY

DATE OF REBURIAL

TIME

PLACE OF REBURIAL

CITY

STATE

COUNTRY

DATE OF RECREMATION

TIME

PLACE OF RECREMATION

CITY

STATE

COUNTRY

DATE OF REEXHUMATION

TIME

PLACE OF REEXHUMATION

CITY

STATE

COUNTRY

DATE OF REINTERMENT

TIME

PLACE OF REINTERMENT

CITY

STATE

COUNTRY

DATE OF REBURIAL

TIME

PLACE OF REBURIAL

CITY

STATE

COUNTRY

DATE OF RECREMATION

TIME

PLACE OF RECREMATION

CITY

STATE

COUNTRY

DATE OF REEXHUMATION

TIME

PLACE OF REEXHUMATION

CITY

STATE

COUNTRY

DATE OF REINTERMENT

TIME

PLACE OF REINTERMENT

CITY

STATE

COUNTRY

DATE OF REBURIAL

TIME

PLACE OF REBURIAL

CITY

STATE

COUNTRY

RECEIVED

BUREAU V. 3

JUN 21 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06240
6251 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 105
1. PLACE OF DEATH a. COUNTY <i>Charles</i>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Charles</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>White Plains</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>White Plains</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>LARRY ELROY HAWKINS</i>					4. DATE OF DEATH <i>6-28-57</i>					
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-26-17</i>	9. AGE (In years last birthday) yrs. <i>40</i>	IF UNDER 1 YEAR Months <i>2</i> Days <i>2</i>	IF UNDER 24 HRS. Hours <i>2</i> Min. <i>0</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>white Plains Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>			
13. FATHER'S NAME <i>WARRREN A HAWKINS</i>					14. MOTHER'S MAIDEN NAME <i>EDNA CAMPBELL</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Warren Hawkins</i> Address <i>white Plains md</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Strangulation</i> 7620 DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Aspiration of vomitus</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <i>6-28-57</i> <i>6-28-57</i>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <i>6</i> m. <i>pm</i> Month, Day, Year <i>6-28-57</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>White Plains Charles</i> (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>E. J. Edelen</i>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>6-28-57</i>					
EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/29/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St Joseph</i>		22d. LOCATION (City, town, or county) (State) <i>Camport Md</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hunt Funeral Home</i>			ADDRESS <i>White Plains</i>		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>M. L. Monrope</i>			
					DATE <i>JUL 2 1957</i>					

4000310XV6

JUL 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6252

CERTIFICATE OF DEATH

06241

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CHARLES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WALDORF</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 WALDORF</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) <b>DONALD LEE HOOD</b>				4. DATE OF DEATH <b>JUNE 15 1957</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 6 1945</b>		9. AGE (In years last birthday) <b>12</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>school</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>school</b>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>JAMES HOOD</b>				14. MOTHER'S MAIDEN NAME <b>MAE PEARSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. MAE GORDON</b>		Address <b>WALDORF, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage, Pulmonary</b> <b>145x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinomatosis</b> DUE TO (c) <b>Cancer Primary of Tonsils</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 15</b> , 19 <b>50</b> , to <b>June 15</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 15</b> , 19 <b>57</b> , and that death occurred at <b>6 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>[Signature]</b>				ADDRESS (Street, city or town, state) <b>Waldorf Md</b>		DATE SIGNED <b>6-17-57</b>	
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-13-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Waldorf, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Huntt Funeral Home</b>				ADDRESS <b>Waldorf, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 19 1957</b> 24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



MANITOWOC STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

RECEIVED

BUREAU V. S.

JUN 19 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06242
6253 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 105
1. PLACE OF DEATH a. COUNTY <b>Charles</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles Pr. Geo.</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Accokeek</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) First <b>EUGENE</b> Middle <b>CLARENCE</b> Last <b>INGRAHAM</b>					4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>1957</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/2/1912</b>		9. AGE (In years last birthday) <b>44</b> yrs.		
						IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Parts Clerk</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Auto</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Edward D. Ingraham</b>					14. MOTHER'S MAIDEN NAME <b>Emma L. Tower</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>578 01 2008</b>		17. INFORMANT <b>Mireta R. Ingraham</b> Address <b>1606 17st, SE Wash., D. C.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fatty Liver</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>Paul F. Guerin</i>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>					DATE SIGNED <b>6/19/57</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-22-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Paul's</b>			22d. LOCATION (City, town, or county) (State) <b>Waldorf, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home</b>					ADDRESS <b>Waldorf, Md.</b>		24. REC'D BY REGISTRAR <b>JUN 25 1957</b>			
					25. REGISTRAR'S SIGNATURE <i>M. L. Monroey</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
John Doe		Male		45		White		June 20, 1957		New York City	
Cause of Death		Manner of Death		Occupation		Education		Marital Status		Previous Illnesses	
Heart Disease		Natural		Teacher		High School		Married		None	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

JUN 25 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

6254 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07384

Item 2 Film 6217 7-12-57 et

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>The Victoria</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D. C.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>1 1/2 day</i>		d. STREET ADDRESS <i>1506 "R" St., N. W.</i>	
3. NAME OF DECEASED (Type or print) First <i>RICHARD</i> Middle <i>F</i> Last <i>JONES JR</i>		DATE OF DEATH Month <i>6</i> Day <i>30</i> Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 6 1919</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sanitary Dept. DC. Borg</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>DR</i>	
11. BIRTHPLACE (State or foreign country) <i>DR</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Richard E. Jones Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Lodie Brown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>yes</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Drowning</i> 850.X DUE TO <i>Capsized Boat</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Capsized Boat</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Boat capsized</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>6-30</i> p. m. <i>1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>River</i>	
20f. (City or town) <i>Monica River Charles</i>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. E. Edelman</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. E. EDELMAN MD</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-5-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mount Airy</i>		22d. LOCATION (City, town, or county) (State) <i>Washington D. C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archibald Inc</i>		ADDRESS <i>Loplaton md.</i>	
24a. REC'D BY REGISTRAR <i>7/6/57</i>		24b. REGISTRAR'S SIGNATURE <i>Julia H. Porey</i>	

MEDICAL CERTIFICATION

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MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF VITAL RECORDS		20. SIGNATURE OF HEALTH DEPARTMENT		21. SIGNATURE OF STATE ARCHIVES	
22. SIGNATURE OF COUNTY ARCHIVES		23. SIGNATURE OF CITY ARCHIVES		24. SIGNATURE OF TOWN ARCHIVES	
25. SIGNATURE OF VILLAGE ARCHIVES		26. SIGNATURE OF PARISH ARCHIVES		27. SIGNATURE OF CHURCH ARCHIVES	
28. SIGNATURE OF SYNAGOGUE ARCHIVES		29. SIGNATURE OF MOSQUE ARCHIVES		30. SIGNATURE OF OTHER ARCHIVES	

RECEIVED  
JUL 9 1957  
BUREAU V. 5



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6255 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06243

Reg. Dist. No. 100

1. PLACE OF DEATH o. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marbury</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				x2 <b>Marbury</b> 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>(SIMONS)</b> Last <b>MADDOX</b>				4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 9 1932</b>	
9. AGE (In years last birthday) <b>25</b> yrs.		IF UNDER 1 YEAR Months <b>25</b> Days <b>20</b> Hours <b>19</b> Min.		IF UNDER 24 HRS. Months <b>25</b> Days <b>20</b> Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fisherman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Fishing</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va</b>	
13. FATHER'S NAME <b>Joseph Simons</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Maddox</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Joseph Simons</b> Address <b>Marbury Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning, Found Drowned.</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <b>Found drowned.</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>3:00</b> p. m. <b>6/15</b> 19 <b>57</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Mattawoman Creek</b>		20f. (City or town) (County) (State) <b>Near Indian Head Charles Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .							
ACTUAL SIGNATURE <b>Paul F. Guerin</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>6/18/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Smiths Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Borgah Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert McRaplala</b>				ADDRESS <b>6/18/57</b>		24a. REC'D BY REGISTRAR <b>Julia H. Poy</b>	
				24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 21 1957

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06244

6256 **CERTIFICATE OF DEATH**

Reg. Dist. No. 106

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Charles</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Charles</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Indian Head</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Indian Head</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>William Joseph MATTINGLY</b>				<b>4. DATE OF DEATH</b> (Month) <b>June 26,</b> (Day) <b>19</b> (Year) <b>57</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>May 10, 1872</b>	<b>9. AGE last birthday</b> <b>85</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>U.S. Gov.</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Ret.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>New York</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>US.</b>	
<b>13. FATHER'S NAME</b> <b>John T. Mattingly</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Eliz. E. Franklin</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No.</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mary E. Mattingly Indian Head, Md.</b>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>420.0 IMMEDIATE CAUSE (A)</b> <b>Respiratory failure</b>						<b>1 day</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Cerebral vascular accident</b>						<b>2 days</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b> <b>Arterio sclerosis heart disease</b>						<b>10 years</b>	
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>331X</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from May 47, 1947, to June 26, 1957, that I last saw the deceased alive on June 26, 1957, and that death occurred at 12:20 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>J. Wood</b>		<b>M.D.</b>		<b>ADDRESS (Street, city, town, state)</b> <b>La Plata, Md.</b>		<b>DATE SIGNED</b> <b>26 Jan 57</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>6-29-57</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>St Joseph's Cem.</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Pomfret, Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Clay Prince</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>The Hunt Funeral Home</b>		<b>ADDRESS</b> <b>Waldorf, Md</b>	
<b>DATE</b> <b>JUL 1 1957</b>							

# CERTIFICATE OF DEATH

File No. 104

1. Name of deceased (Print or write full name)

2. Sex

3. Age

4. Race

5. Date of birth

6. Place of birth

7. Date of death

8. Cause of death

9. Date of death

10. Place of death

11. Signature of physician

12. Signature of registrar

13. Signature of medical examiner

14. Signature of coroner

15. Signature of health officer

16. Signature of registrar

BUREAU V. 1

JUL 1 1957

RECEIVED

86 January 1957

NOTES: This certificate is to be filed in the office of the Registrar of Deaths, State Department of Health, Baltimore, Maryland. It is to be used for the purpose of recording the death of a person who has died in Maryland. It is to be filled out by the physician or other person who has attended the deceased, or by the coroner or health officer if the death is sudden or unexpected. It is to be signed by the physician or other person who has attended the deceased, or by the coroner or health officer if the death is sudden or unexpected. It is to be signed by the physician or other person who has attended the deceased, or by the coroner or health officer if the death is sudden or unexpected.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6257 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G216 6-17-57 et

06049  
100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Pr. Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>2nd Lata Md</i>		c. LENGTH OF STAY IN 1b <i>4 hrs.</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Segattsville</i>		16152	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Phy's Mem. Hosp</i>		d. STREET ADDRESS <i>7509-25th Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>MARGARET</i> First <i>McMANNIS</i> Middle <i>McMANNIS</i> Last		4. DATE OF DEATH Month <i>6</i> Day <i>8</i> Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 7 1916</i>
9. AGE (In years and birthday) <i>40</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H.W.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>W.C.A.</i>	
11. BIRTHPLACE (State or foreign country) <i>W.C.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Lloyd C McCauley</i>		14. MOTHER'S MAIDEN NAME <i>Betty Belle Stewart</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-42-6103</i>	
17. INFORMANT <i>Glynn A. Mc Mannis</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> 816X DUE TO <i>Abdominal hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Multiple lacerations and contusions</i> (b) <i>6-8-57</i> (c) <i>Multiple lacerations and contusions</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <i>2 car auto accident</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <i>6-8 1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>301 highway</i>		20f. (City or town) <i>Mdury Ches</i> (County) <i>Ms.</i> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>K. Hedelen</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>F. J. EDELEN</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-13-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Joseph's</i>		22d. LOCATION (City, town, or county) <i>Charmers Manor Md</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Samuel Harris - Wash DC</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>12 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Julia Posy</i>	



NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME		LAST	
FIRST		MIDDLE	
CITY		COUNTY	
STATE		ZIP	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARRIAGE		PREVIOUS DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
DATE OF DEATH		PLACE OF DEATH	
SIGNATURE OF EXAMINER		DATE	
OFFICIAL SEAL		STAMP	

BUREAU V. S.

JUN 12 1957

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 (10)

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06245

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

6258

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>La Plata Md</u>		<u>3-days</u>		TOWN <u>Indian Head Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hosp. La Plata Md.</u>				STREET ADDRESS (If rural give location) <u>11-Irwin Place Potomac Heights</u>			
3. NAME OF DECEASED (Type or Print) <u>Dora Posey</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>6-14-57</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W-US</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>2-13-1870</u>	
9. AGE last birthday <u>87</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days)		11. IF UNDER 24 HRS. (Hours) (Min.)			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Charles County Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>Charles Henry Posey</u>				14. MOTHER'S MAIDEN NAME <u>Susan Julia Posey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT'S ADDRESS <u>Doris Morgan Hedges, 14-E-60th St. New York City</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary Heart Disease</u>						10-Yrs	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>Arterio-Sclerosis</u>						Indefinite	
DUE TO (C) <u>Senility</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April</u> ....., 19 <u>54</u> ....., to <u>6-14-57</u> ....., 19....., that I last saw the deceased alive on <u>6-14-57</u> ....., 19....., and that death occurred at <u>5-15 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>James E. Andrews MD.</u>				DATE SIGNED <u>6-15-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Funeral</u>		DATE THEREOF <u>6-17-57</u>		NAME OF CEMETERY OR CREMATORY <u>St. Charles</u>		LOCATION (City, town, or county) (State) <u>Flisomont Md</u>	
24. REC'D BY REGISTRAR <u>6/18/57</u>		REGISTRAR'S SIGNATURE <u>James E. Andrews</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Crehanthe Laplata</u>		ADDRESS	

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6259

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G217 6-28-57 et.

06246

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <i>So. Carol.</i> b. COUNTY <i>Georgetown</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lafayette</i>		c. LENGTH OF STAY IN 1b <i>1 mo.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>77X-3</i>	
3. NAME OF DECEASED (Type or print) <i>LeRoy</i> First <i>Reed</i> Middle Last		4. DATE OF DEATH Month <i>6</i> Day <i>14</i> Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-24-29</i>
9. AGE (In years last birthday) <i>27</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Tobacco</i>	
11. BIRTHPLACE (State or foreign country) <i>Georgetown S.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Reed</i>		14. MOTHER'S MAIDEN NAME <i>Louise Conner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>982x Hemorrhage</i> DUE TO (b) <i>stab wound of chest</i> DUE TO (c) <i>cutting one of the great blood vessels</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <i>6-14-57</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Stabbed by assailant</i>	
20c. TIME OF INJURY Month, Day, Year <i>19</i> Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Lafayette</i> (County) <i>Char.</i> (State) <i>So. Carol.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. J. Edelen</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. J. EDELEN M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>6-15-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>6-20-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Georgetown</i>		22d. LOCATION (City, town, or county) <i>Georgetown S.C.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles H. P. P. P.</i>		ADDRESS <i>77X-3</i>	
24a. REC'D BY REGISTRAR <i>6/20/57</i>		24b. REGISTRAR'S SIGNATURE <i>Julia M. P. P.</i>	

JUN 24 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06247

## 6260 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Ohio</i> b. COUNTY <i>Delaware</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Spring Hill</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Delaware 72 x -3</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Thomas Michael Ryan</i> First Middle Last				4. DATE OF DEATH Month <i>6</i> Day <i>8</i> Year <i>1957</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-8-31</i>	9. AGE (In years last birthday) <i>25</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 MRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Officer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S.A.F.</i>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Daniel Francis Ryan</i>				14. MOTHER'S MAIDEN NAME <i>Leona Margaret</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Capt. J. E. Bell</i> Address <i>Bolling A. F. Base D.C.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture Skull</i> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>air Crushed Chest</i> DUE TO (c) <i>Auto accident</i>							INTERVAL BETWEEN ONSET AND DEATH <i>6-8-57</i> <i>6-8-57</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Car Collision, auto</i>					
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>at 561</i>		20f. (City or town) (County) (State) <i>Del.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. J. Edelen</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>E. J. EDELEN M.D.</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-10-57</i>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <i>Delaware Ohio</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers Co.</i>				ADDRESS <i>517-11th St. S.E.</i>		24a. REC'D BY REGISTRAR <i>J. J. Lacey</i>	
				DATE <i>JUN 12 1957</i>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

BUREAU V. R.

JUN 12 1957

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06248

6261

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>La Plata</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rock Point, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>John W. Shorter</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>June 14</u> 19 <u>57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widower</u>	8. DATE OF BIRTH <u>Sept 30 1873</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret. farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John W. Shorter</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Long</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Wm. Nichols Washington</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
443X IMMEDIATE CAUSE (A) <u>Congestive heart failure</u>						<u>1 yr.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>Hypertension</u>		<u>7</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M., from the causes and on the date stated above.</b> SIGNATURE <u>[Signature]</u> ADDRESS (Street, city, town, state) <u>6-15-57</u> DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>buried</u>		<u>6/17/57</u>		<u>Holy Ghost</u>		<u>Wm. Nichols</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>6/8/57</u>		<u>Julia H. Casey</u>		<u>Wm. Nichols</u>		<u>Washington</u>	

BUREAU V. S.

7501 12 N07

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. **FOR** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

6262

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07392  
782

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ironsides</u>		c. LENGTH OF STAY IN 1b <u>x0</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LAWRENCE E. STAFFORD</u>		4. DATE OF DEATH Month <u>6</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 23, 1904</u>
9. AGE (In years (with birthday) yrs. <u>52</u> )		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Writer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Financial</u>	11. BIRTHPLACE (State or foreign country) <u>Minnesota</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Harry H. Stafford</u>	
14. MOTHER'S MAIDEN NAME <u>Edith Bayley</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>WWII</u>	
16. SOCIAL SECURITY NO. <u>363-05-3857</u>		17. INFORMANT Address <u>Mary M. Stafford (Wife), Ironsides, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6-30-57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. J. EDLEN</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDLEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/3/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Newton S...</u> ADDRESS <u>1756 Pennsylvania Ave NW, Washington, DC</u>		24a. REC'D BY REGISTRAR <u>July 5 1957</u> 24b. REGISTRAR'S SIGNATURE <u>V. Thompson</u>	



BUREAU V. S.

JUL 8 1957

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06249

6263

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Bryans Road</i>		<i>20 yrs</i>		TOWN <i>Bryans Road</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<i>1</i>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<i>Robert</i> (First) <i>Thomas</i> (Middle) <i>Thomas</i> (Last)				<i>June 2</i> 19 <i>57</i>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<i>Male</i>	<i>Colored</i>	<i>Widowed</i>	<i>March 17, 1848</i>	<i>109</i> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<i>Farmer</i>		<i>Farm</i>		<i>Port Tobacco, Md</i>		<i>U.S.</i>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<i>Not Known</i>				<i>Not Known</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<i>No</i>		<i>None</i>		<i>Gracie Thomas. Washington DC</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>331X IMMEDIATE CAUSE (A)</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<i>Cerebral Hemorrhage</i>						<i>3 wks.</i>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>							
<b>STATING UNDERLYING CAUSE LAST.</b>							
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <i>May 8</i>, 19 <i>57</i>, to <i>June 2</i>, 19 <i>57</i>, that I last saw the deceased alive on <i>June 1</i>, 19 <i>57</i>, and that death occurred at <i>8 P.</i> M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>	
<i>Frank A. Pusan</i>				<i>Indian Head, Md</i>		<i>6-2-57</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<i>Burial</i>		<i>June 5 1957</i>		<i>Macehoma Burial</i>		<i>Bryans Road Md</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<i>JUN 7 1957</i>		<i>Julia Posey</i>		<i>Huntt Funeral Home</i>		<i>Waldorf Md</i>	

RECEIVED

JUN 7 1957

BURKAY Y. L.

1. NAME OF DEATH		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. DATE OF BIRTH		11. TIME OF BIRTH		12. PLACE OF BIRTH	
13. NAME OF DEATH		14. SEX		15. AGE	
16. DATE OF DEATH		17. TIME OF DEATH		18. PLACE OF DEATH	
19. CAUSE OF DEATH		20. MANNER OF DEATH		21. PLACE OF BIRTH	
22. DATE OF BIRTH		23. TIME OF BIRTH		24. PLACE OF BIRTH	
25. NAME OF DEATH		26. SEX		27. AGE	
28. DATE OF DEATH		29. TIME OF DEATH		30. PLACE OF DEATH	
31. CAUSE OF DEATH		32. MANNER OF DEATH		33. PLACE OF BIRTH	
34. DATE OF BIRTH		35. TIME OF BIRTH		36. PLACE OF BIRTH	
37. NAME OF DEATH		38. SEX		39. AGE	
40. DATE OF DEATH		41. TIME OF DEATH		42. PLACE OF DEATH	
43. CAUSE OF DEATH		44. MANNER OF DEATH		45. PLACE OF BIRTH	
46. DATE OF BIRTH		47. TIME OF BIRTH		48. PLACE OF BIRTH	
49. NAME OF DEATH		50. SEX		51. AGE	
52. DATE OF DEATH		53. TIME OF DEATH		54. PLACE OF DEATH	
55. CAUSE OF DEATH		56. MANNER OF DEATH		57. PLACE OF BIRTH	
58. DATE OF BIRTH		59. TIME OF BIRTH		60. PLACE OF BIRTH	
61. NAME OF DEATH		62. SEX		63. AGE	
64. DATE OF DEATH		65. TIME OF DEATH		66. PLACE OF DEATH	
67. CAUSE OF DEATH		68. MANNER OF DEATH		69. PLACE OF BIRTH	
70. DATE OF BIRTH		71. TIME OF BIRTH		72. PLACE OF BIRTH	
73. NAME OF DEATH		74. SEX		75. AGE	
76. DATE OF DEATH		77. TIME OF DEATH		78. PLACE OF DEATH	
79. CAUSE OF DEATH		80. MANNER OF DEATH		81. PLACE OF BIRTH	
82. DATE OF BIRTH		83. TIME OF BIRTH		84. PLACE OF BIRTH	
85. NAME OF DEATH		86. SEX		87. AGE	
88. DATE OF DEATH		89. TIME OF DEATH		90. PLACE OF DEATH	
91. CAUSE OF DEATH		92. MANNER OF DEATH		93. PLACE OF BIRTH	
94. DATE OF BIRTH		95. TIME OF BIRTH		96. PLACE OF BIRTH	
97. NAME OF DEATH		98. SEX		99. AGE	
100. DATE OF DEATH		101. TIME OF DEATH		102. PLACE OF DEATH	
103. CAUSE OF DEATH		104. MANNER OF DEATH		105. PLACE OF BIRTH	
106. DATE OF BIRTH		107. TIME OF BIRTH		108. PLACE OF BIRTH	
109. NAME OF DEATH		110. SEX		111. AGE	
112. DATE OF DEATH		113. TIME OF DEATH		114. PLACE OF DEATH	
115. CAUSE OF DEATH		116. MANNER OF DEATH		117. PLACE OF BIRTH	
118. DATE OF BIRTH		119. TIME OF BIRTH		120. PLACE OF BIRTH	
121. NAME OF DEATH		122. SEX		123. AGE	
124. DATE OF DEATH		125. TIME OF DEATH		126. PLACE OF DEATH	
127. CAUSE OF DEATH		128. MANNER OF DEATH		129. PLACE OF BIRTH	
130. DATE OF BIRTH		131. TIME OF BIRTH		132. PLACE OF BIRTH	
133. NAME OF DEATH		134. SEX		135. AGE	
136. DATE OF DEATH		137. TIME OF DEATH		138. PLACE OF DEATH	
139. CAUSE OF DEATH		140. MANNER OF DEATH		141. PLACE OF BIRTH	
142. DATE OF BIRTH		143. TIME OF BIRTH		144. PLACE OF BIRTH	
145. NAME OF DEATH		146. SEX		147. AGE	
148. DATE OF DEATH		149. TIME OF DEATH		150. PLACE OF DEATH	
151. CAUSE OF DEATH		152. MANNER OF DEATH		153. PLACE OF BIRTH	
154. DATE OF BIRTH		155. TIME OF BIRTH		156. PLACE OF BIRTH	
157. NAME OF DEATH		158. SEX		159. AGE	
160. DATE OF DEATH		161. TIME OF DEATH		162. PLACE OF DEATH	
163. CAUSE OF DEATH		164. MANNER OF DEATH		165. PLACE OF BIRTH	
166. DATE OF BIRTH		167. TIME OF BIRTH		168. PLACE OF BIRTH	
169. NAME OF DEATH		170. SEX		171. AGE	
172. DATE OF DEATH		173. TIME OF DEATH		174. PLACE OF DEATH	
175. CAUSE OF DEATH		176. MANNER OF DEATH		177. PLACE OF BIRTH	
178. DATE OF BIRTH		179. TIME OF BIRTH		180. PLACE OF BIRTH	
181. NAME OF DEATH		182. SEX		183. AGE	
184. DATE OF DEATH		185. TIME OF DEATH		186. PLACE OF DEATH	
187. CAUSE OF DEATH		188. MANNER OF DEATH		189. PLACE OF BIRTH	
190. DATE OF BIRTH		191. TIME OF BIRTH		192. PLACE OF BIRTH	
193. NAME OF DEATH		194. SEX		195. AGE	
196. DATE OF DEATH		197. TIME OF DEATH		198. PLACE OF DEATH	
199. CAUSE OF DEATH		200. MANNER OF DEATH		201. PLACE OF BIRTH	
202. DATE OF BIRTH		203. TIME OF BIRTH		204. PLACE OF BIRTH	
205. NAME OF DEATH		206. SEX		207. AGE	
208. DATE OF DEATH		209. TIME OF DEATH		210. PLACE OF DEATH	
211. CAUSE OF DEATH		212. MANNER OF DEATH		213. PLACE OF BIRTH	
214. DATE OF BIRTH		215. TIME OF BIRTH		216. PLACE OF BIRTH	
217. NAME OF DEATH		218. SEX		219. AGE	
220. DATE OF DEATH		221. TIME OF DEATH		222. PLACE OF DEATH	
223. CAUSE OF DEATH		224. MANNER OF DEATH		225. PLACE OF BIRTH	
226. DATE OF BIRTH		227. TIME OF BIRTH		228. PLACE OF BIRTH	
229. NAME OF DEATH		230. SEX		231. AGE	
232. DATE OF DEATH		233. TIME OF DEATH		234. PLACE OF DEATH	
235. CAUSE OF DEATH		236. MANNER OF DEATH		237. PLACE OF BIRTH	
238. DATE OF BIRTH		239. TIME OF BIRTH		240. PLACE OF BIRTH	
241. NAME OF DEATH		242. SEX		243. AGE	
244. DATE OF DEATH		245. TIME OF DEATH		246. PLACE OF DEATH	
247. CAUSE OF DEATH		248. MANNER OF DEATH		249. PLACE OF BIRTH	
250. DATE OF BIRTH		251. TIME OF BIRTH		252. PLACE OF BIRTH	
253. NAME OF DEATH		254. SEX		255. AGE	
256. DATE OF DEATH		257. TIME OF DEATH		258. PLACE OF DEATH	
259. CAUSE OF DEATH		260. MANNER OF DEATH		261. PLACE OF BIRTH	
262. DATE OF BIRTH		263. TIME OF BIRTH		264. PLACE OF BIRTH	
265. NAME OF DEATH		266. SEX		267. AGE	
268. DATE OF DEATH		269. TIME OF DEATH		270. PLACE OF DEATH	
271. CAUSE OF DEATH		272. MANNER OF DEATH		273. PLACE OF BIRTH	
274. DATE OF BIRTH		275. TIME OF BIRTH		276. PLACE OF BIRTH	
277. NAME OF DEATH		278. SEX		279. AGE	
280. DATE OF DEATH		281. TIME OF DEATH		282. PLACE OF DEATH	
283. CAUSE OF DEATH		284. MANNER OF DEATH		285. PLACE OF BIRTH	
286. DATE OF BIRTH		287. TIME OF BIRTH		288. PLACE OF BIRTH	
289. NAME OF DEATH		290. SEX		291. AGE	
292. DATE OF DEATH		293. TIME OF DEATH		294. PLACE OF DEATH	
295. CAUSE OF DEATH		296. MANNER OF DEATH		297. PLACE OF BIRTH	
298. DATE OF BIRTH		299. TIME OF BIRTH		300. PLACE OF BIRTH	
301. NAME OF DEATH		302. SEX		303. AGE	
304. DATE OF DEATH		305. TIME OF DEATH		306. PLACE OF DEATH	
307. CAUSE OF DEATH		308. MANNER OF DEATH		309. PLACE OF BIRTH	
310. DATE OF BIRTH		311. TIME OF BIRTH		312. PLACE OF BIRTH	
313. NAME OF DEATH		314. SEX		315. AGE	
316. DATE OF DEATH		317. TIME OF DEATH		318. PLACE OF DEATH	
319. CAUSE OF DEATH		320. MANNER OF DEATH		321. PLACE OF BIRTH	
322. DATE OF BIRTH		323. TIME OF BIRTH		324. PLACE OF BIRTH	
325. NAME OF DEATH		326. SEX		327. AGE	
328. DATE OF DEATH		329. TIME OF DEATH		330. PLACE OF DEATH	
331. CAUSE OF DEATH		332. MANNER OF DEATH		333. PLACE OF BIRTH	
334. DATE OF BIRTH		335. TIME OF BIRTH		336. PLACE OF BIRTH	
337. NAME OF DEATH		338. SEX		339. AGE	
340. DATE OF DEATH		341. TIME OF DEATH		342. PLACE OF DEATH	
343. CAUSE OF DEATH		344. MANNER OF DEATH		345. PLACE OF BIRTH	
346. DATE OF BIRTH		347. TIME OF BIRTH		348. PLACE OF BIRTH	
349. NAME OF DEATH		350. SEX		351. AGE	
352. DATE OF DEATH		353. TIME OF DEATH		354. PLACE OF DEATH	
355. CAUSE OF DEATH		356. MANNER OF DEATH		357. PLACE OF BIRTH	
358. DATE OF BIRTH		359. TIME OF BIRTH		360. PLACE OF BIRTH	
361. NAME OF DEATH		362. SEX		363. AGE	
364. DATE OF DEATH		365. TIME OF DEATH		366. PLACE OF DEATH	
367. CAUSE OF DEATH		368. MANNER OF DEATH		369. PLACE OF BIRTH	
370. DATE OF BIRTH		371. TIME OF BIRTH		372. PLACE OF BIRTH	
373. NAME OF DEATH		374. SEX		375. AGE	
376. DATE OF DEATH		377. TIME OF DEATH		378. PLACE OF DEATH	
379. CAUSE OF DEATH		380. MANNER OF DEATH		381. PLACE OF BIRTH	
382. DATE OF BIRTH		383. TIME OF BIRTH		384. PLACE OF BIRTH	
385. NAME OF DEATH		386. SEX		387. AGE	
388. DATE OF DEATH		389. TIME OF DEATH		390. PLACE OF DEATH	
391. CAUSE OF DEATH		392. MANNER OF DEATH		393. PLACE OF BIRTH	
394. DATE OF BIRTH		395. TIME OF BIRTH		396. PLACE OF BIRTH	
397. NAME OF DEATH		398. SEX		399. AGE	
400. DATE OF DEATH		401. TIME OF DEATH		402. PLACE OF DEATH	
403. CAUSE OF DEATH		404. MANNER OF DEATH		405. PLACE OF BIRTH	
406. DATE OF BIRTH		407. TIME OF BIRTH		408. PLACE OF BIRTH	
409. NAME OF DEATH		410. SEX		411. AGE	
412. DATE OF DEATH		413. TIME OF DEATH		414. PLACE OF DEATH	
415. CAUSE OF DEATH		416. MANNER OF DEATH		417. PLACE OF BIRTH	
418. DATE OF BIRTH		419. TIME OF BIRTH		420. PLACE OF BIRTH	
421. NAME OF DEATH		422. SEX		423. AGE	
424. DATE OF DEATH		425. TIME OF DEATH		426. PLACE OF DEATH	
427. CAUSE OF DEATH		428. MANNER OF DEATH		429. PLACE OF BIRTH	
430. DATE OF BIRTH		431. TIME OF BIRTH		432. PLACE OF BIRTH	
433. NAME OF DEATH		434. SEX		435. AGE	
436. DATE OF DEATH		437. TIME OF DEATH		438. PLACE OF DEATH	
439. CAUSE OF DEATH		440. MANNER OF DEATH		441. PLACE OF BIRTH	
442. DATE OF BIRTH		443. TIME OF BIRTH		444. PLACE OF BIRTH	
445. NAME OF DEATH		446. SEX		447. AGE	
448. DATE OF DEATH		449. TIME OF DEATH		450. PLACE OF DEATH	
451. CAUSE OF DEATH		452. MANNER OF DEATH		453. PLACE OF BIRTH	
454. DATE OF BIRTH		455. TIME OF BIRTH		456. PLACE OF BIRTH	
457. NAME OF DEATH		458. SEX		459. AGE	
460. DATE OF DEATH		461. TIME OF DEATH		462. PLACE OF DEATH	
463. CAUSE OF DEATH		464. MANNER OF DEATH		465. PLACE OF BIRTH	
466. DATE OF BIRTH		467. TIME OF BIRTH		468. PLACE OF BIRTH	
469. NAME OF DEATH		470. SEX		471. AGE	
472. DATE OF DEATH		473. TIME OF DEATH		474. PLACE OF DEATH	
475. CAUSE OF DEATH		476. MANNER OF DEATH		477. PLACE OF BIRTH	
478. DATE OF BIRTH		479. TIME OF BIRTH		480. PLACE OF BIRTH	
481. NAME OF DEATH		482. SEX		483. AGE	
484. DATE OF DEATH		485. TIME OF DEATH		486. PLACE OF DEATH	
487. CAUSE OF DEATH		488. MANNER OF DEATH		489. PLACE OF BIRTH	
490. DATE OF BIRTH		491. TIME OF BIRTH		492. PLACE OF BIRTH	
493. NAME OF DEATH		494. SEX		495. AGE	
496. DATE OF DEATH		497. TIME OF DEATH		498. PLACE OF DEATH	
499. CAUSE OF DEATH		500. MANNER OF DEATH		501. PLACE OF BIRTH	
502. DATE OF BIRTH		503. TIME OF BIRTH		504. PLACE OF BIRTH	
505. NAME OF DEATH		506. SEX		507. AGE	
508. DATE OF DEATH		509. TIME OF DEATH		510. PLACE OF DEATH	
511. CAUSE OF DEATH		512. MANNER OF DEATH		513. PLACE OF BIRTH	
514. DATE OF BIRTH		515. TIME OF BIRTH		516. PLACE OF BIRTH	
517. NAME OF DEATH		518. SEX		519. AGE	
520. DATE OF DEATH		521. TIME OF DEATH		522. PLACE OF DEATH	
523. CAUSE OF DEATH		524. MANNER OF DEATH		525. PLACE OF BIRTH	
526. DATE OF BIRTH		527. TIME OF BIRTH		528. PLACE OF BIRTH	
529. NAME OF DEATH		530. SEX		531. AGE	
532. DATE OF DEATH		533. TIME OF DEATH		534. PLACE OF DEATH	
535. CAUSE OF DEATH		536. MANNER OF DEATH		537. PLACE OF BIRTH	
538. DATE OF BIRTH		539. TIME OF BIRTH		540. PLACE OF BIRTH	
541. NAME OF DEATH		542. SEX		543. AGE	
544. DATE OF DEATH		545. TIME OF DEATH		546. PLACE OF DEATH	
547. CAUSE OF DEATH		548. MANNER OF DEATH		549. PLACE OF BIRTH	
550. DATE OF BIRTH		551. TIME OF BIRTH		552. PLACE OF BIRTH	
553. NAME OF DEATH		554. SEX		555. AGE	
556. DATE OF DEATH		557. TIME OF DEATH		558. PLACE OF DEATH	
559. CAUSE OF DEATH		560. MANNER OF DEATH		561. PLACE OF BIRTH	
562. DATE OF BIRTH		563. TIME OF BIRTH		564. PLACE OF BIRTH	
565. NAME OF DEATH		566. SEX		567. AGE	
568. DATE OF DEATH		569. TIME OF DEATH		570. PLACE OF DEATH	
571. CAUSE OF DEATH		572. MANNER OF DEATH		573. PLACE OF BIRTH	
574. DATE OF BIRTH		575. TIME OF BIRTH		576. PLACE OF BIRTH	
577. NAME OF DEATH		578. SEX		579. AGE	
580. DATE OF DEATH		581. TIME OF DEATH		582. PLACE OF DEATH	
583. CAUSE OF DEATH		584. MANNER OF DEATH		585. PLACE OF BIRTH	
586. DATE OF BIRTH		587. TIME OF BIRTH		588. PLACE OF BIRTH	
589. NAME OF DEATH		590. SEX		591. AGE	
592. DATE OF DEATH		593. TIME OF DEATH		594. PLACE OF DEATH	
595. CAUSE OF DEATH		596. MANNER OF DEATH		597. PLACE OF BIRTH	
598. DATE OF BIRTH		599. TIME OF BIRTH		600. PLACE OF BIRTH	
601. NAME OF DEATH		602. SEX		603. AGE	
604. DATE OF DEATH		605. TIME OF DEATH		606. PLACE OF DEATH	
607. CAUSE OF DEATH		608. MANNER OF DEATH		609. PLACE OF BIRTH	
610. DATE OF BIRTH		611. TIME OF BIRTH		612. PLACE OF BIRTH	
613. NAME OF DEATH		614. SEX		615. AGE	
616. DATE OF DEATH		617. TIME OF DEATH		618. PLACE OF DEATH	
619. CAUSE OF DEATH		620. MANNER OF DEATH		621. PLACE OF BIRTH	
622. DATE OF BIRTH		623. TIME OF BIRTH		624. PLACE OF BIRTH	
625. NAME OF DEATH		626. SEX		627. AGE	
628. DATE OF DEATH		629. TIME OF DEATH		630. PLACE OF DEATH	
631. CAUSE OF DEATH		632. MANNER OF DEATH		633. PLACE OF BIRTH	
634. DATE OF BIRTH		635. TIME OF BIRTH		636. PLACE OF BIRTH	
637. NAME OF DEATH		638. SEX		639. AGE	
640. DATE OF DEATH		641. TIME OF DEATH		642. PLACE OF DEATH	
643. CAUSE OF DEATH		644. MANNER OF DEATH		645. PLACE OF BIRTH	
646. DATE OF BIRTH		647. TIME OF BIRTH		648. PLACE OF BIRTH	
649. NAME OF DEATH		650. SEX		651. AGE	
652. DATE OF DEATH		653. TIME OF DEATH		654. PLACE OF DEATH	
655. CAUSE OF DEATH		656. MANNER OF DEATH		657. PLACE OF BIRTH	
658. DATE OF BIRTH		659. TIME OF BIRTH		660. PLACE OF BIRTH	
661. NAME OF DEATH		662. SEX		663. AGE	
664. DATE OF DEATH		665. TIME OF DEATH		666. PLACE OF DEATH	
667. CAUSE OF DEATH		668. MANNER OF DEATH		669. PLACE OF BIRTH	
670. DATE OF BIRTH		671. TIME OF BIRTH		672. PLACE OF BIRTH	
673. NAME OF DEATH		674. SEX		675. AGE	
676. DATE OF DEATH		677. TIME OF DEATH		678. PLACE OF DEATH	
679. CAUSE OF DEATH		680. MANNER OF DEATH		681. PLACE OF BIRTH	
682. DATE OF BIRTH		683. TIME OF BIRTH		684. PLACE OF BIRTH	
685. NAME OF DEATH		686. SEX		687. AGE	
688. DATE OF DEATH		689. TIME OF DEATH		690. PLACE OF DEATH	
691. CAUSE OF DEATH		692. MANNER OF DEATH		693. PLACE OF BIRTH	
694. DATE OF BIRTH		695. TIME OF BIRTH		696. PLACE OF BIRTH	
697. NAME OF DEATH		698. SEX		699. AGE	
700. DATE OF DEATH		701. TIME OF DEATH		702. PLACE OF DEATH	
703. CAUSE OF DEATH		704. MANNER OF DEATH		705. PLACE OF BIRTH	
706. DATE OF BIRTH		707. TIME OF BIRTH		708. PLACE OF BIRTH	
709. NAME OF DEATH		710. SEX		711. AGE	
712. DATE OF DEATH		713. TIME OF DEATH		714. PLACE OF DEATH	
715. CAUSE OF DEATH		716. MANNER OF DEATH		717. PLACE OF BIRTH	
718. DATE OF BIRTH		719. TIME OF BIRTH		720. PLACE OF BIRTH	
721. NAME OF DEATH		722. SEX		723. AGE	
724. DATE OF DEATH		725. TIME OF DEATH		726. PLACE OF DEATH	
727. CAUSE OF					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

1  
6264  
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
item 2 11.12 See: Birth Cert. et  
item 1 Film 6217 6-24-57 et

06250  
100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>En-route to La Plata</u>		c. LENGTH OF STAY IN 1b <u>McConchie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Auto enroute</u>		d. STREET ADDRESS <u>---</u>	
3. NAME OF DECEASED (Type or print) First <u>Luponne</u> Middle <u>Thomas</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>6</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-14-57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>McConchie, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alvin Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Mary Florence Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suf. Asphyx</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>571.0</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6-1-57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. Medlen</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>F. J. EDELIN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 4 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prud. of Richard Thomas</u>		22d. LOCATION (City, town, or county) (State) <u>McConchie Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Perhart Inc</u>		ADDRESS <u>Lopleston</u>	
24a. REC'D BY REGISTRAR <u>6/10/57</u>		24b. REGISTRAR'S SIGNATURE <u>John H. B...</u>	

4000256XV6

RECEIVED

JUN 12 1957

BUREAU V. S.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

6265

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06251

Reg. Dist. No.

100

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hughesville (Rural)</b>		c. LENGTH OF STAY IN 1b <b>0</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY</b>		4. DATE OF DEATH Month <b>6</b> - Day <b>9</b> Year <b>19 57</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1903</b>
9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William W. Toye</b>		14. MOTHER'S MAIDEN NAME <b>Jane Estep</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unk</b>	
17. INFORMANT <b>DeSales B. Toye</b>		Address <b>Hughesville Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>STAB WOUND OF AORTA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R. S. FISHER</b>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R. S. FISHER</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/9/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-12-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Mary's Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Bryantown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home</b>		ADDRESS <b>Waldorf, Md.</b>	
24a. REC'D BY REGISTRAR <b>6/12/57</b>		24b. REGISTRAR'S SIGNATURE <b>Julia Rosey</b>	

DECEASED

NAME

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

TIME OF DEATH

PLACE OF BURIAL

NAME OF BURIAL PLACE

NAME OF MINISTER

NAME OF WITNESSES

NAME OF CORONER

NAME OF JURY

NAME OF JUDGE

NAME OF CLERK

NAME OF SHERIFF

NAME OF DEPUTY SHERIFF

NAME OF CONSTABLE

NAME OF JURY

NAME OF JUDGE

NAME OF CLERK

NAME OF SHERIFF

NAME OF DEPUTY SHERIFF

NAME OF CONSTABLE

NAME OF JURY

NAME OF JUDGE

NAME OF CLERK

NAME OF SHERIFF

NAME OF DEPUTY SHERIFF

NAME OF CONSTABLE

RECEIVED  
JUN 13 1957  
BUREAU V. A.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06252

6266

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CHARLES</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>CHARLES</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>LA PLATA</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>LA PLATA</u>		STREET ADDRESS (If rural give location) <u>WILCOMICO STREET</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PHYSICIANS' MEMORIAL HOSPITAL</u>				1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MARY</u>		(Middle) <u>BERNADETTE</u>		(Last) <u>WALKER</u>		(Month) <u>JUNE</u> (Day) <u>28</u> (Year) <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W-U.S.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>JUNE 26, 1957</u>	9. AGE last birthday <u>—</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>10</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>THOMAS JEFFERSON WALKER</u>				14. MOTHER'S MAIDEN NAME <u>ESTELLA ELIZABETH HUNT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>THOMAS J. WALKER</u> <u>LA PLATA, MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
761.5 IMMEDIATE CAUSE (A) <u>EXCESSIVE PREMATUREITY (EDC-10/12/57)</u>						<u>34 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>MALDEVELOPMENT OF CENTRAL NERVOUS SYSTEM</u>						<u>34 hrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>SYSTEM</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>MARGINAL PLACENTA PREVIA (MATERNAL)</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>—</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/26</u> , 19 <u>57</u> , to <u>6/28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/28</u> , 19 <u>57</u> , and that death occurred at <u>6:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>John H. Buffen</u>				ADDRESS (Street, city, town, state) <u>Hughesville Md.</u>		DATE SIGNED <u>6/28/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>6-28-57</u>		NAME OF CEMETERY OR CREMATORY <u>St Peters Cem.</u>		LOCATION (City, town, or county) (State) <u>WALDORF, MD.</u>	
24. REC'D BY REGISTRAR <u>JUL 1 1957</u>		REGISTRAR'S SIGNATURE <u>Julia Possey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		ADDRESS <u>WALDORF, MD.</u>	

2066263XVO

# CERTIFICATE OF DEATH

REG. NO. 100

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MEDICAL CERTIFICATION

BUREAU V. E.

JUL 1 1957

RECEIVED

Handwritten notes and signatures at the bottom of the page.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06253

6267

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Charles</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>La Plata</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Potomac Heights, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>JOSEPH WILLIAM WHITE</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>June 12 1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>April 18/57</u>	9. AGE last birthday <u>XXXXX</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Lawrence White</u>				14. MOTHER'S MAIDEN NAME <u>Alice Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
571.0 IMMEDIATE CAUSE (A) <u>diarrhea + dehydration</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>pneumonia</u>				<u>3 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>493X</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>6-12</u>, 19<u>57</u>, to <u>6-12</u>, 19<u>57</u>, that I last saw the deceased alive on <u>6-12</u>, 19<u>57</u>, and that death occurred at <u>9:57</u> M, from the causes and on the date stated above.</b>							
SIGNATURE <u>[Signature]</u>		M.D.		ADDRESS (Street, city, town, state) <u>La Plata Md</u>		DATE SIGNED <u>6-12-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>6/12/57</u>		<u>Old Gore Baptist Church Cemetery</u>		<u>Nanjemoy, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>6/12/57</u>		<u>Julia H. Pacey</u>		<u>Fairlee</u>			

4000297XV0



# CERTIFICATE OF DEATH

Form 10-1-57

1. Name of deceased (Print or write)

2. Sex

3. Date of birth

4. Place of birth

5. Usual residence

6. Cause of death

7. Date of death

8. Place of death

9. Signature of physician

10. Signature of registrar

11. Signature of informant

12. Date of registration

13. Place of registration

14. Signature of registrar

15. Date of registration

16. Place of registration

17. Signature of registrar

18. Date of registration

19. Place of registration

20. Signature of registrar

21. Date of registration

22. Place of registration

23. Signature of registrar

24. Date of registration

25. Place of registration

26. Signature of registrar

27. Date of registration

28. Place of registration

29. Signature of registrar

30. Date of registration

31. Place of registration

32. Signature of registrar

33. Date of registration

34. Place of registration

35. Signature of registrar

36. Date of registration

37. Place of registration

38. Signature of registrar

39. Date of registration

40. Place of registration

41. Signature of registrar

42. Date of registration

43. Place of registration

44. Signature of registrar

45. Date of registration

46. Place of registration

47. Signature of registrar

48. Date of registration

49. Place of registration

BUREAU V. S.

JUN 17 1957

RECEIVED

WILLIAMSON

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

STATE OF MARYLAND  
6268 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 11 Film 0216 6-19-57 et

06254

Reg. Dist. No.

100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Pa.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Spring Hill</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edwardsville Pa</i>	
3. NAME OF DECEASED (Type or print) <i>JAMES</i> First <i>EDWARD</i> Middle <i>WILSON</i> Last		4. DATE OF DEATH Month <i>6</i> Day <i>8</i> Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-24-30</i>
9. AGE (In years last birthday) <i>26</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <i>Edwardsville, Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph Wilson</i>		14. MOTHER'S MAIDEN NAME <i>Ruth Elmer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, for unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Capt. L.E. Bell</i>		Address <i>Bolling A. F. Base</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture base of skull</i> 816X DUE TO <i>Crushed Chest</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>Auto accident</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6-8-57</i> <i>6-8-57</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Car collision auto</i>	
20c. TIME OF INJURY Month, Day, Year <i>19</i> Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>6301</i>		20f. (City or town) (County) (State) <i>Ches.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. J. E. DeLena</i>		DATE SIGNED <i>6-8-57</i>	
EXAMINER'S NAME (Type) <i>E. J. E. DELEN M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-10-57</i>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <i>Edwardsville Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chamber Co.</i>		ADDRESS <i>517-11th St. S.E.</i>	
24a. REC'D BY REGISTRAR <i>JULIA POSEY</i>		24b. REGISTRAR'S SIGNATURE <i>JULIA POSEY</i>	

**BUREAU V. S.**

NOV 11 1957

RECEIVED